STATE OF MICHIGAN

IN THE SUPREME COURT

APPEAL FROM THE COURT OF APPEALS

COVENANT MEDICAL CENTER, INC.,	Supreme Court No. 152758
Plaintiff/Appellee,	COA Docket No. 322108
v	Lower Court Case No. 13-020416-NF Saginaw County Circuit Court
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,	
Defendant/Appellant.	

Richard E. Hillary, II (P56092) Christopher J. Schneider (P74457) Miller Johnson Attorneys for Plaintiff/Appellee 45 Ottawa Avenue, S.W., Suite 1100 Grand Rapids, MI 49503 (616) 831-1700	Jill M. Wheaton (P49921) Courtney F. Kissel (P74179) Dykema Gossett PLLC Attorneys for Defendant/Appellant 2723 S. State Street, Ste. 400 Ann Arbor, MI 48104 (734) 215-7629

Brief on Appeal—Appellee Covenant Medical Center

*****ORAL ARGUMENT REQUESTED*****

Table of Contents

Table of Contents
(continued)

Page

Index of Authorities

Page

Cases

Index of Authorities
(continued)

Page

Index of Authorities
(continued)

Page

Statutes

Index of Authorities
(continued)

Other Authorities

Rules

Statement of Jurisdiction

Covenant concurs in State Farm's statement of jurisdiction.

Counter-Statement of Questions Presented

I. The plain language of the no-fault act gives healthcare providers the right to charge a reasonable amount for treatment; requires insurers to pay those reasonable charges; makes PIP benefits separately payable to the injured person or a claimant; and authorizes lawsuits by claimants, not just injured persons. Based on this, our courts have uniformly held that healthcare providers have claims for no-fault benefits against no-fault insurers. Our courts have further held that those claims are derivative of the injured person's eligibility for benefits, but otherwise independent. **Does a healthcare provider have an independent claim for no-fault benefits against a no-fault insurer when the injured person is eligible for no-fault benefits?**

Covenant's answer:	Yes.
State Farm's answer:	No.
Circuit Court would answer:	N/A
Court of Appeals would answer:	Yes

II. The phrase "some other person" in MCL 500.3112 means an undetermined or unspecified legal entity different from the "person who [the insurer] believes is entitled to the benefits." When an insurer pays the injured person, a healthcare provider is an undetermined or unspecified legal entity different from the injured person. Indeed, "person" and "injured person" have different statutory definitions. **Is a healthcare provider "some other person" within the meaning of the second sentence of MCL 500.3112?**

Covenant's answer:	Yes.
State Farm's answer:	No.
Circuit Court would answer:	N/A
Court of Appeals would answer:	Yes

III. Under MCL 500.3112, an insurer's good faith payment discharges its liability to the extent of the payment, unless the insurer has notice in writing of the claim of some other person. The statute further provides that, if an insurer has "doubt about the proper person to receive the benefits," then it "may" apply to the circuit court for "an appropriate order." **If an insurer chooses not to have a hearing, does it remain liable for a healthcare provider's noticed claims per the statute's "unless" clause?**

Covenant's answer:	Yes.
State Farm's answer:	No.
Circuit Court's answer:	No.
Court of Appeals' answer:	Yes.

Introduction and Summary of the Argument

The no-fault insurance act is "a comprehensive statutory scheme of reparation with the objective of providing assured, adequate and prompt recovery for certain economic losses," like medical treatment.[1] To this end, the act's plain language gives healthcare providers independent claims for no-fault benefits when the injured person is eligible for benefits. The act gives providers the right to "charge a reasonable amount" for treatment of an injured person who is eligible for PIP benefits. MCL 500.3157. And it requires insurers to pay those reasonable charges. MCL 500.3107(1)(a). The act also imposes on insurers twin payment obligations: benefits (like allowable expenses) are required to be paid to the injured person or, alternatively, benefits are required to be paid to claimants, like healthcare providers. MCL 500.3112. The act also contemplates that "claimants," not just injured persons, will sue for unpaid benefits, and it gives all claimants the right to seek penalties. MCL 500.3145, .3142, and .3148.

Based on these statutes, our courts uniformly have held that a healthcare provider has an independent claim for no-fault benefits when the injured person is eligible for no-fault benefits. Indeed, no case holds that healthcare providers *do not* have a claim for benefits.

Under the no-fault act and our jurisprudence, a healthcare provider has a claim for no-fault benefits against the no-fault insurer, and that claim is both derivative and independent. It is derivative of the injured person's *eligibility* for no-fault benefits—*i.e.*, the injured person must have suffered an accidental bodily injury arising out of a motor vehicle accident and must not be excluded from coverage by a statutory or permissible policy exclusion. But otherwise, the healthcare provider's claim is independent. The provider's claim may be governed by a separate statute of limitations; the provider must prove that its charges are reasonable and customary; and

[1] *Perez v State Farm Mut Auto Ins Co*, 418 Mich 634, 647; 344 NW2d 773 (1984).

the provider must prove that the treatment was reasonably necessary. Healthcare providers have an independent claim for no-fault benefits when the injured person is eligible for benefits.

Regardless of whether a provider's claim is characterized as "independent" or "derivative," a healthcare provider is "some other person" under the second sentence of MCL 500.3112. That phrase means an undetermined or unspecified legal entity different from the person who the insurer believes is entitled to the benefits. When an insurer pays benefits to the injured person, the insurer believes that the injured person is entitled to the benefits. A healthcare provider is a legal entity different from the injured person. As such, the healthcare provider is "some other person" within the meaning of the second sentence of MCL 500.3112. Accordingly, an insurer's settlement payment to the injured person does not discharge the insurer's liability to the provider if the insurer had notice in writing of the provider's claim before settling with the injured person, as State Farm did here.

When an insurer has notice in writing of a provider's claim before settling with the injured person, MCL 500.3112 allows the insurer to apply to the circuit court for an appropriate order. But if the insurer chooses not to seek an order, then the settlement does not discharge the insurer's liability for the healthcare provider's noticed claim. The insurer cannot nullify MCL 500.3112's "unless" clause through a release signed only by the injured person. This is what the Court of Appeals correctly held in this case. Accordingly, Covenant requests that this Court affirm the Court of Appeals in all respects.

Statement of Facts

A. Jack Stockford's accident and treatment at Covenant.

On June 20, 2011, Jack Stockford, State Farm's insured, was injured in a motor vehicle accident. (Complaint, JA 4a, ¶5.) On June 28, 2012, July 25-27, 2012, and October 3, 2012, Covenant provided medical care and treatment to Mr. Stockford for injuries arising out of

that accident. (Complaint, JA 4a, ¶8.) Covenant's charges for this care and treatment total $43,484.80. (Complaint, JA 4a, ¶9.) These are the charges at issue.

B. State Farm receives written notice of Covenant's claim and responds with a written denial.

On July 3, 2012, August 2, 2012, and October 9, 2012, Covenant billed State Farm for its care and treatment of Mr. Stockford. Covenant provided to State Farm copies of Covenant's UB-04 billing forms, itemized statements, and medical records. (Complaint, JA 4a, ¶11.) That is, on these dates, Covenant provided to State Farm notice in writing of Covenant's claim. State Farm admits this.

On November 15, 2012, State Farm responded to Covenant's claim with a written denial. (*See* Complaint, JA 5a, ¶14; State Farm's Denial, JA 45a). State Farm denied coverage, alleging that Covenant's care and treatment of Mr. Stockford was not reasonably necessary. *Id.*

When Covenant billed State Farm and when State Farm responded, Covenant was unaware of Mr. Stockford's lawsuit against State Farm.[2] Neither State Farm nor Mr. Stockford informed Covenant of that lawsuit.

C. Months after receiving and responding to Covenant's claim, State Farm settles Mr. Stockford's lawsuit without Covenant's knowledge.

On April 2, 2013—*six months* after State Farm received written notice of Covenant's claims for no-fault benefits and more than *four months* after State Farm responded to those claims—State Farm settled with Mr. Stockford.

State Farm paid Mr. Stockford $59,000, and Mr. Stockford signed a release. (JA 17a-20a) Although the release mentions Covenant's treatment, Covenant was not a party to it. Neither State Farm nor Mr. Stockford's attorney contacted Covenant before the settlement. In

[2] *Stockford v State Farm Mut Auto Ins Co*, Case No. 12-016370-CK-1, Saginaw Circuit Court, Judge Fred Borchard.

other words, State Farm paid no-fault benefits to only Mr. Stockford, even though State Farm had received and responded to written notice of Covenant's claim months before.

D. Covenant sues State Farm, and the circuit court grants State Farm's motion for summary disposition.

On April 25, 2013, Covenant sued State Farm to recover no-fault benefits for its care and treatment of Mr. Stockford. On May 28, 2013, State Farm filed its answer and attached a copy of the settlement. This is when Covenant first learned of the settlement between Mr. Stockford and State Farm.

On September 20, 2013, State Farm filed a summary disposition motion based on the settlement. On February 3, 2014, the circuit court heard oral argument.

At the hearing, State Farm made two important admissions. First, State Farm admitted that healthcare providers, like Covenant, are independent claimants under the no-fault act. (Tr. of 2/3/14 MSD Hearing, JA 63a, p. 5:12-17)("[W]e don't take exception to the cases that plainly have now said there is a *direct right of reimbursement* . . . I do not quarrel with anything [counsel for Covenant] cited in his brief in that regard.")(emphasis added). Second, State Farm admitted that it had received notice in writing of Covenant's claim before it settled with Mr. Stockford. *Id* at JA 65a, p. 7:14-15 ("In this particular case, State Farm had knowledge of a claim . . . .") and JA 67a, p. 9:4-5 ("So, with that, Your Honor, the fact that Covenant was known is not determinative.").

On May 15, 2014, the circuit court issued an opinion and order granting State Farm's motion. The circuit court concluded that the settlement barred Covenant's no-fault claim, even though State Farm had written notice of Covenant's claim before it settled with Mr. Stockford. (May 15, 2014 Opinion and Order, JA 77a-78a, p. 5-6.)

E. The Court of Appeals reverses the Circuit Court.

Covenant appealed. In a unanimous, published opinion, the Court of Appeals reversed. *Covenant Med Ctr, Inc v State Farm Mut Auto Ins Co*, 313 Mich App 50; 880 NW2d 294 (2015). The court held that, because State Farm had received notice in writing of Covenant's claim before State Farm settled with Mr. Stockford, State Farm's settlement payment did not discharge Covenant's claim per MCL 500.3112. (*Id* at 3.) The court reasoned:

> MCL 500.3112 provides that if the insurer does not have notice in writing of any other claims to payment for a particular covered service, then a good faith payment to its insured is a discharge of its liability for that service. ***However, the plain text of the statute provides that if the insurer has notice in writing of a third party's claim, then the insurer cannot discharge its liability to the third party simply by settling with its insured.*** Such a payment is not in good faith because the insurer is aware of a third party's right and seeks to extinguish it without providing notice to the affected third party. Instead, the statute requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated. That was not done in this case. Accordingly, pursuant to the plain language of the statute, because State Farm had notice in writing of Covenant Medical's claim, State Farm's payment to Stockford did not discharge its liability to Covenant Medical. [*Id* at 53 (emphasis added).]

The Court of Appeals further held that State Farm and Mr. Stockford could not settle Covenant's claim after State Farm received notice in writing of the claim:

> State Farm also relies on *Moody v Home Owners Ins Co*, 304 Mich App 415; 849 NW2d 31 (2014). *Moody* made it clear that a provider's right to no-fault benefits is based on the insured's right to benefits. *Id*. at 442. However, it is also well settled that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits. *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389, 396-397; 864 NW2d 598 (2014); *Moody*, 304 Mich App at 440; *Mich Head & Spine*, 299 Mich App at 448 n 1; *Lakeland Neurocare Ctrs*, 250 Mich App at 42-43; *Regents of Univ of Michigan v State Farm Mut Ins Co*, 250 Mich App 719, 733; 650 NW2d 129 (2002). And while a provider's right to payment from the insurer is created by the right of the insured to benefits, an insured's agreement to release the insurer in exchange for a

> settlement does not release the insurer with respect to the provider's noticed claims unless the insurer complies with MCL 500.3112. This is implicitly recognized in the text of the release itself, which provides that Stockford agreed to "indemnify, defend and hold harmless" State Farm "from any liens or demands made by any provider, . . . including . . . Covenant Medical . . . , for payments made or services rendered . . . in connection with any injuries resulting" from the accident. [*Id* at 53-55.]

F. This Court grants State Farm's application for leave to appeal.

State Farm sought leave to appeal. On May 27, 2016, this Court granted that application and directed the parties to address three issues:

> (1) Whether a healthcare provider has an independent or derivative claim against a no-fault insurer for no-fault benefits; (2) whether a healthcare provider constitutes "some other person" within the meaning of the second sentence of MCL 500.3112; and (3) the extent to which a hearing is required by MCL 500.3112.

Standard of Review

The lower courts' rulings on State Farm's motion for summary disposition are reviewed *de novo*. *Maiden v Rozwood*, 461 Mich 109; 597 NW2d 817 (1999); *Associated Builders & Contractors v Wilbur*, 472 Mich 117, 123; 693 NW2d 374 (2005). Questions of statutory interpretation are also reviewed *de novo*. *Elba Twp v Gratiot County Drain Comm'r*, 493 Mich 265, 278; 831 NW2d 204 (2013).

Argument

I. A HEALTHCARE PROVIDER HAS AN INDEPENDENT CLAIM AGAINST A NO-FAULT INSURER FOR NO-FAULT BENEFITS WHEN THE INJURED PERSON IS ELIGIBLE FOR BENEFITS.

A. The plain language of the no-fault act gives a healthcare provider an independent claim when the injured person is eligible for benefits.

Whether a healthcare provider's claim against a no-fault insurer for no-fault benefits is independent or derivative presents issues of statutory interpretation. The primary goal of statutory interpretation is to give effect to the Legislature's intent, which is best indicated by

the words used. *Jesperson v Auto Club Ins Ass'n*, 499 Mich 29, 34; 878 NW2d 799 (2016). Unless statutorily defined, every word of a statute should be accorded its plain and ordinary meaning, taking into account the context in which the words are used. *Krohn v Home-Owners Ins Co*, 490 Mich 145, 156; 802 NW2d 281 (2011). Our courts avoid an interpretation that renders nugatory or surplusage any part of a statute. *Jesperson*, *supra*. If the statutory language is unambiguous, then the Legislature's intent is clear and judicial construction is neither necessary nor permitted. *Douglas v Allstate Ins Co*, 492 Mich 241, 256; 821 NW2d 472 (2012).

The plain language of the no-fault act gives a healthcare provider an independent claim for no-fault benefits when the injured person is eligible for no-fault benefits, and the provider can enforce that claim through a lawsuit against the insurer.

1. MCL 500.3105(1), .3107, and .3157 give a healthcare provider an independent right to be paid by the no-fault insurer when the injured person is eligible for no-fault benefits.

MCL 500.3105(1) requires no-fault insurers to pay benefits for eligible bodily injuries: "[A]n insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter." MCL 500.3105 does not limit *to whom* insurers must pay benefits. Rather, an eligible injury triggers the insurer's payment obligation, subject to the provisions of the act. Later sections show that a healthcare provider has an independent claim against a no-fault insurer when the injured person is eligible for no-fault benefits (*i.e.*, has suffered an eligible injury and is not excluded by a coverage exclusion).

For example, MCL 500.3107 and .3157 give a healthcare provider the right to be paid by the no-fault insurer for treatment of an injured person. Under MCL 500.3107(1)(a), no-fault benefits "are ***payable*** for . . . [a]llowable expenses consisting of all reasonable ***charges*** incurred for reasonably necessary products services and accommodations for the injured person's

care, recovery, or rehabilitation." (Emphasis added.) The word "payable" means "to be paid; due." *Random House Webster's College Dictionary* (2005). Thus, under MCL 500.3107(a), no-fault benefits are "to be paid" by the insurer for all "reasonable charges" for medical treatment.

In turn, MCL 500.3157 gives healthcare providers the right to charge a reasonable amount for treatment. That statute states:

> ***A physician, hospital, clinic or other person or institution lawfully rendering treatment*** to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, ***may charge a reasonable amount*** for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance. [(Emphasis added.)]

This language gives healthcare providers the right to "charge a reasonable amount" for treatment. This right is subject to the injured person's eligibility for no-fault benefits, as demonstrated by the phrase "to an injured person for an accidental bodily injury covered by personal protection insurance." But it is the healthcare provider's right nonetheless. The plain language of MCL 500.3107(1)(a) and .3157 gives healthcare providers the right to "charge a reasonable amount" and requires no-fault insurers to pay those "reasonable charges." Accordingly, the provider has a right to have the insurer pay the provider's reasonable charges.

If healthcare providers did not have a right to payment from the no-fault insurer, then MCL 500.3157 would be nugatory. MCL 500.3107(1)(a) requires an insurer to pay "all reasonable charges" for the injured person's medical treatment. If only the injured person had a right to that payment, then the Legislature did not need to give healthcare providers the right to charge a reasonable amount. The injured person could simply rely on MCL 500.3107(1)(a) for payment of his or her reasonable medical expenses. MCL 500.3157 would be meaningless.

In giving healthcare providers the right to "charge a reasonable amount" and requiring insurers to pay those "reasonable charges" the Legislature gave providers the right to be paid by the insurer. Because healthcare providers have the right to be paid by the insurer for "treatment to an injured person for an accidental bodily injury covered by personal protection insurance," they have an independent claim for no-fault benefits against the insurer, when the injured person is eligible for benefits.

State Farm claims that MCL 500.3157 merely limits the amount that a healthcare provider can charge. (State Farm Br., p. 17.) But this argument contravenes the statute's plain language. The first sentence states that healthcare providers "may" charge a reasonable amount. "May" is commonly "used to express possibility" or "used to express opportunity or permission." *Random House Webster's College Dictionary* (2005). By using the word "may," the Legislature plainly gave healthcare providers the opportunity and permission—*i.e.*, the right—to charge a reasonable amount. The first sentence of MCL 500.3157 does not merely limit the amount that a provider can charge. Rather, it gives providers the right to charge a reasonable amount for treatment.

The second sentence of MCL 500.3157 further demonstrates this. That sentence *does* limit the amount that a healthcare provider may charge. To do so, the Legislature used the phrase "shall not exceed," instead of the permissive word "may." The first sentence of MCL 500.3157 gives healthcare providers the right to charge a reasonable amount, and the second sentence limits a reasonable amount to no more than the provider's customary charge. State Farm's argument to the contrary contravenes this plain meaning.

State Farm also argues that the word "incurred" in MCL 500.3107(1)(a) shows that only the injured person has a claim for no-fault benefits. But this argument rests on the false

premise that only the injured person incurs the expense of medical treatment. As State Farm admits, "incur" means "to become liable for" or "to suffer or bring on oneself (a liability or expense)." (State Farm Br., p. 17)(*citing Bombalski v Auto Club Ins Ass'n*, 247 Mich App 536; 637 NW2d 251 (2001).) When a healthcare provider treats an injured person, the provider fronts the cost of the treatment, including the cost of medical supplies, salaries, overhead, etc. If neither the insurer nor the injured person pays, then the provider absorbs those charges. Accordingly, a healthcare provider incurs the cost of treatment because the provider is liable for or suffers that cost unless and until its charges are paid. Because a healthcare provider also incurs the cost of medical treatment, the word "incurred" in MCL 500.3107(1)(a) does not mean that only the injured person has a claim for no-fault benefits. *See Lakeland Neurocare Centers v State Farm Mut Auto Ins Co*, 250 Mich App 35, 43; 645 NW2d 59 (2002) (noting that the provider "had incurred the loss of income, the use of that income, the interest it would bear, its investment potential, and the additional expense of legal action.").

Additionally, State Farm's argument reads into MCL 500.3107(1)(a) words that are not there. The statute defines "allowable expenses" as "all reasonable charges incurred for" medical treatment, not as "all reasonable charges incurred *by the injured person* for" medical treatment. State Farm's argument contravenes this plain language.

MCL 500.3107 and .3157 plainly give healthcare providers the right to charge a reasonable amount for treatment of eligible injured persons, and they require the insurer to pay those reasonable charges. Accordingly, the Legislature has given providers an independent claim for no-fault benefits against a no-fault insurer when the injured person is eligible for benefits.

2. MCL 500.3112 imposes on an insurer twin payment obligations, which give a healthcare provider an independent claim for no-fault benefits when the injured person is eligible for benefits.

MCL 500.3112, the statute that identifies to whom no-fault benefits are payable, also shows that a healthcare provider has an independent claim. The first sentence of MCL 500.3112 states: "Personal protection insurance benefits are ***payable*** to or ***for the benefit of an injured person*** . . . ." (Emphasis added.) Again, the word "payable" means "to be paid; due." *Random House Webster's College Dictionary* (2005). And the phrase "to or for the benefit of an injured person" means that no-fault benefits are payable to either the injured person or another claimant. If the insurer's payment obligation ran only to an injured person, then this phrase would be rendered nugatory. The statute could simply state that PIP benefits "are payable to an injured person." Thus, when read as a whole, the phrase "payable to or for the benefit of an injured person" means that an insurer is to pay no-fault benefits due to the injured person or is to pay no-fault benefits due to another claimant.

Put simply, the first sentence of MCL 500.3112 describes a no-fault insurer's two independent payment obligations: (1) an insurer is required to pay no-fault benefits to an injured person; *or* (2) an insurer is required to pay no-fault benefits to another claimant, like a healthcare provider. Because MCL 500.3112 states disjunctive payment obligations, each payee has an independent claim to enforce the payment obligation running to that payee.[3]

Contrary to State Farm's argument, the phrase "for the benefit of an injured person" does not mean that a healthcare provider's claim is wholly derivative of the injured person's claim. Rather, that phrase demonstrates that the insurer is required to pay the provider's independent claim. The word "benefit" means "something that is advantageous or good."

[3] MCL 500.3107b further evidences these two independent payment obligations. That statute refers to "reimbursement or coverage" for PIP expenses.

Random House Webster's College Dictionary (2005). When an insurer pays a medical bill "for the benefit of an injured person," the insurer does so for the advantage or good of the injured person—*i.e.*, on behalf of the injured person. *See AOPP v Auto Club Ins Ass'n*, 257 Mich App 365, 376; 670 NW2d 569 (2003). The *insurer*, not the *provider*, stands in the shoes of the insured when it pays the injured person's debt *to the healthcare provider*. In other words, the insurer steps into the debtor's shoes and pays *the provider's claim*. At bottom, the claim paid is the provider's claim for its reasonable charges.

To the extent that the phrase "for the benefit of an injured person" makes the provider's claim derivative of the injured person's claim, it merely means that the injured person must be eligible for no-fault benefits before the insurer is obligated to pay the provider's claim. An "injured person" is "a natural person suffering accidental bodily injury." MCL 500.3109(2). Thus, under the first sentence of MCL 500.3112 and under MCL 500.3105(1), an insurer is required to pay no-fault benefits "to or for the benefit of" a natural person suffering accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle—*i.e.*, if the injured person is eligible for no-fault benefits.

The phrase "for the benefit of an injured person" does not mean that the provider's claim and the injured person's claim are the same. Nor does it mean that the injured person owns the provider's claim. Rather, the statute provides for two independent payment obligations, and a healthcare provider has a right to enforce the payment obligation running to it.

State Farm also argues that the word "or" in the first sentence of MCL 500.3112 means that an insurer can choose whether to pay benefits to the injured person or to a healthcare provider. (State Farm Br., p. 19.) But State Farm's argument incorrectly reads "or" in isolation. When read in context, the word "or" delineates the insurer's two independent payment

obligations, not a choice between payees. The word "or" is "used to connect words, phrases, or clauses representing alternatives." *Random House Webster's College Dictionary* (2005). In the first sentence of MCL 500.3112, the word "payable" precedes the word "or." As explained above, "payable" means "to be paid; due." Thus, the phrase "[p]ersonal protection insurance benefits are payable to or for the benefit of an injured person" means that PIP benefits are *to be paid/due* to an injured person or, *alternatively*, PIP benefits are *to be paid/due* for the benefit of an injured person. The word "or" in the first sentence of MCL 500.3112 disjunctively connects the insurer's two payment obligations. It does not give an insurer the choice between payees for a single payment obligation, as State Farm claims.

The third sentence of MCL 500.3112 supports this conclusion. That sentence describes what an insurer, claimant or interested person can do when "there is doubt about the proper person to receive the benefits . . . ." If State Farm's argument were correct, then there would be no doubt about the proper person to receive PIP benefits. The insurer could simply choose a payee. But the third sentence of MCL 500.3112 plainly contemplates situations where "doubt about the proper person to receive the benefits" exists—like when a healthcare provider and insured make a claim for the same medical charges. State Farm's interpretation of the word "or" ignores the context in which that word appears.

State Farm argues that the third sentence of MCL 500.3112 is limited to doubt about whether someone is a dependent eligible to receive survivor's loss benefits. But the third sentence of MCL 500.3112 refers to "the proper *person* to receive the benefits." (Emphasis added.) The Insurance Code (of which the no-fault act is part) defines the word "person" to include corporate entities, like healthcare providers. MCL 500.114. Thus, the third sentence of MCL 500.3112 plainly contemplates competing claims for no-fault benefits between or among

natural persons and/or corporate entities. That sentence is not limited to doubt about whether a natural person is a dependent eligible to receive survivor's loss benefits.

The plain language of MCL 500.3108 and .3110 further supports this conclusion. MCL 500.3108 defines "survivor's loss," and MCL 500.3110 defines "dependents." These sections precede MCL 500.3112. If the third sentence of MCL 500.3112 were limited to doubt about whether a person is a dependent eligible to receive survivor's loss, then the Legislature would have used those defined terms. But the Legislature drafted the third sentence in broad terms, referring to doubt about the proper *person* (not *dependent*) to receive any kind of no-fault *benefit* (not just survivor's loss). State Farm's argument improperly substitutes narrowly defined terms for the broad terms that the Legislature actually used. *See Murphy v Dairyland Ins Co*, 417 Mich 602, 605; 339 NW2d 628 (1983)(Legislature would have used a statutorily-defined, narrow term if it had intended to do so).

The plain language of MCL 500.3112—particularly when read in conjunction with MCL 500.3107 and .3157—demonstrates that the Legislature gave healthcare providers an independent claim for their reasonable charges when the insured is eligible for no-fault benefits.

3. MCL 500.3145 and .3148 allow healthcare providers to bring lawsuits to enforce their independent claims.

While the statutory sections discussed above demonstrate that providers have independent claims for no-fault benefits, MCL 500.3145(1) and .3148 allow healthcare providers to bring lawsuits to enforce those independent claims. Under MCL 500.3145(1), "[a]n action for recovery of [PIP] benefits payable under this chapter for accidental bodily injury may not be commenced more than 1 year after the date of the accident causing the injury . . . ." Although phrased as a statute of limitations, this language contemplates that lawsuits to recover PIP benefits will be brought within one year of the date of the accident. MCL 500.3145(1) does not

allow only the "injured person" to bring a lawsuit. Rather, the statute plainly allows a timely lawsuit "for recovery of [PIP] benefits *payable under this chapter*." (Emphasis added.) Under MCL 500.3107, .3157, and .3112, allowable expenses are "payable" to healthcare providers. As such, MCL 500.3145(1) contemplates that providers will bring lawsuits to recover benefits.

The third sentence of MCL 500.3145(1) further demonstrates this. It states: "However, *the claimant* may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced." (Emphasis added.) The Legislature's use of the word "claimant" instead of "injured person" demonstrates that other persons, like healthcare providers, may bring lawsuits to recover PIP benefits.

MCL 500.3148 buttresses the conclusion that healthcare providers have the right to bring an independent lawsuit for payment of PIP benefits. That section also uses the word "claimant," not "injured person." MCL 500.3148(1) provides:

> An attorney is entitled to a reasonable fee for advising and representing a ***claimant*** in an action for personal or property protection insurance benefits which are overdue. The attorney's fee shall be a charge against the insurer ***in addition to the benefits recovered***, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment. [(Emphasis added.)]

This plain language contemplates that a "claimant," not just an injured person, will bring a lawsuit and will recover, from the insurer, PIP benefits due to the claimant.

MCL 500.3148(2) further demonstrates that the benefits recovered in a lawsuit are "due to the claimant." That statute allows an insurer to recover an attorney's fee for fraudulent or excessive claims. The second sentence states: "To the extent that personal . . . protection insurance benefits are ***then due or thereafter come due to the claimant*** because of loss resulting from the injury on which the claim is based, such a fee may be treated as an offset against such

benefits . . . ." (Emphasis added.) This language plainly contemplates that benefits are "due to the claimant," not just the injured person, for loss resulting from eligible injuries.

State Farm incorrectly argues that the word "claimant" means only injured persons and their dependents. (State Farm Br., p. 15.) The act defines "injured person" and "dependent." If the Legislature had intended to allow only those persons to bring a lawsuit, it would have used those specific terms. *Murphy*, *supra*. But the Legislature used the word "claimant," which means "a person who makes a claim." *Random House Webster's College Dictionary* (2005). A "claim," in turn, means "to demand by or as if by virtue of a right; demand as a right or as due." *Id.* A healthcare provider is a claimant because the provider makes a claim—a demand as due—for allowable expenses. Accordingly, the Legislature's use of the word "claimant" in MCL 500.3145(1) and .3148 demonstrates that claimants other than the injured person, like healthcare providers, can bring an independent action to recover benefits payable under the act.[4]

4. MCL 500.3105(4) demonstrates the relationship between a provider's claim and the injured person's claim.

MCL 500.3105(4) encapsulates the relationship between a provider's independent claim and an injured person's claim. That section, the intentional injury exclusion, states in relevant part:

> Bodily injury is accidental as to ***a person claiming personal protection insurance benefits*** unless suffered intentionally by the ***injured person*** or caused intentionally by the ***claimant***. [(Emphasis added.)]

[4] State Farm incorrectly asserts that MCL 500.3114 defines "claimants" as persons suffering accidental bodily injury. (State Farm's Br., p. 14.) But MCL 500.3114 does not define the word "claimant." Rather, MCL 500.3114 states the general rule that a no-fault policy "*applies to accidental bodily injury* to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, *if the injury arises from a motor vehicle accident*." (Emphasis added.) That is, MCL 500.3114, like the rest of the act, ties payment of benefits to eligible injuries. It then states the order of priority among policies for payment of benefits. It does not exclude providers as claimants.

Under this language, a "person" claims PIP benefits, and a "person" includes both a healthcare provider and an injured person. *See* MCL 500.114. If the "person" claiming benefits is the "injured person," then bodily injury is not accidental only if the injured person intentionally caused it. This is because, in that circumstance, the injured person and the claimant are the same.

But if the "person" claiming PIP benefits is someone other than the injured person—*i.e.*, a "claimant"—then bodily injury is not accidental if *either* the injured person or the *claimant* intentionally causes the injury. This additional eligibility requirement for claimants demonstrates that a claimant's claim is separate from the injured person's claim. *Stated differently, a claimant has an independent claim that can be barred by the claimant's own conduct when the injured person has suffered an otherwise eligible injury.*

State Farm has not cited to any part of the no-fault act that denies healthcare providers a claim for no-fault benefits. Nor has State Farm cited any part of the act that makes a provider's claim wholly derivative of the injured person's claim. And there is none.

On the contrary, the Legislature wrote the act to give healthcare providers the right to charge a reasonable amount for treatment of eligible injured persons (MCL 500.3157); to require insurers to pay those reasonable charges (MCL 500.3107); to make benefits separately payable to the insured or other claimants, like healthcare providers (MCL 500.3112); and to authorize lawsuits by "claimants," not just injured persons (MCL 500.3145 and .3148). Of course, the insurer's payment obligations depend on the injured person's eligibility for benefits (MCL 500.3105). But if the injured person is eligible, then the injured person and claimants, like healthcare providers, have independent claims for no-fault benefits. The plain language of the

act gives a healthcare provider an independent claim for no-fault benefits against the no-fault insurer when the injured person is eligible for benefits.

B. Case law has consistently and correctly held that a healthcare provider has an independent claim for no-fault benefits against a no-fault insurer when the injured person is eligible for benefits.

Consistent with the plain language of the no-fault act, our courts have for decades held that a healthcare provider has a claim for no-fault benefits against a no-fault insurer. They have further held that this claim is independent, except that it is derivative of the injured person's eligibility for no-fault benefits (*i.e.*, the injured person has suffered an eligible accidental bodily injury and is not excluded under a statutory or permissible policy coverage exclusion).

1. Our courts have uniformly held that a healthcare provider has a claim for no-fault benefits against a no-fault insurer.

One of the first cases to hold that a healthcare provider has a right to be paid by a no-fault insurer was *Munson Med Ctr v Auto Club Ins Ass'n*, 218 Mich App 375, 381-82; 554 NW2d 49 (1996).[5] Between 1973 (the year the no-fault act passed) and 1992, Munson had treated ACIA's insureds for covered injuries; Munson had billed ACIA; and ACIA had paid those bills in full. But sin 1992, ACIA started paying only a portion of Munson's charges, based on the workers' compensation schedule. ACIA claimed that, because Munson accepted less from other insurers (like BCBS, Medicare, and Medicaid), its billed charges were not its customary charges. Munson claimed that its billed charges were its customary charges because it billed the same amount to everyone. Thus, the issue in *Munson* was the meaning of the term "customar[y] charges" in MCL 500.3157.

[5] As discussed below, *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55; 535 NW2d 529 (1995), held that medical providers are the real parties in interest for claims involving their medical charges. And prior cases involved medical provider plaintiffs and even standing issues. But those cases did not squarely address the provider's right to payment. *E.g.*, *Johnson v Michigan Mut Auto Ins Co*, 180 Mich App 314; 446 NW2d 899 (1989), leave to appeal denied, 434 Mich 906 (1990); *Botsford Gen Hosp v Citizens Ins Co*, 195 Mich App 127; 489 NW2d 137 (1992).

To decide that issue, the Court of Appeals first addressed whether the no-fault act gave Munson a right to be paid by ACIA. Relying on MCL 500.3105, .3107, and .3157, the court held that Munson had that right. The court reasoned:

> Under Michigan's no-fault act . . . when a person is injured in an automobile-related accident, a hospital that provides medical care is to be reimbursed by the injured person's no-fault insurance company. . . . ***ACIA's obligation to pay and Munson's right to be paid for the injureds' no-fault medical expenses arise pursuant to MCL 500.3105, 500.3107, and 500.3157***. . . . Under this statutory scheme, ACIA is required to pay the "customary charges" for services rendered by Munson. [*Id* at 378-82 (emphasis added).]

In other words, the court found that MCL 500.3105, .3107, and .3157 give a healthcare provider the *right* to be paid by a no-fault insurer. As discussed above, this holding is consistent with the plain language of those statutes. Because a provider has a statutory right to be paid by a no-fault insurer, the provider has an independent claim to enforce that right.[6]

State Farm incorrectly argues that the provider's right to claim PIP benefits was not at issue in *Munson*. (State Farm Br., p. 23.) But it was. To define the term "customary charge," the Court of Appeals first had to determine whether Munson had a right to be paid under the act—*i.e.*, a right to claim PIP benefits. The court held that Munson had that right.

State Farm also argues that the word "right" in *Munson* really means "ability to receive payment." But the Court of Appeals did not say this. Rather, the court said that Munson had "a right to be paid" by ACIA, and the court meant what it said.

After *Munson*, the Court of Appeals again held that a provider has a claim for no-fault benefits against a no-fault insurer in *Lakeland Neurocare Centers v State Farm Mut Auto Ins Co*, 250 Mich App 35; 645 NW2d 59 (2002). There, Lakeland Neurocare sought no-fault penalties under MCL 500.3142 and .3148 because State Farm had failed to pay benefits timely.

[6] This Court denied ACIA's application for leave to appeal in *Munson*, 453 Mich 959; 564 NW2d 887 (1996).

State Farm refused to pay penalties, arguing—like it does now—that only the injured person, not a healthcare provider, has a claim for no-fault penalties.

The Court of Appeals rejected State Farm's argument and held that a healthcare provider, as a claimant under the act, can enforce the act's penalty provisions. In concluding that Lakeland Neurocare could enforce the penalty interest statute, MCL 500.3142, the Court of Appeals held that Lakeland Neurocare had properly submitted a *claim* for PIP benefits:

> These statutes resolve in favor of plaintiff the issue whether plaintiff, a health care provider, is entitled to attempt enforcement of the penalty interest provision of the no-fault act. MCL 500.3105(1) imposes liability on an insurer to pay personal protection insurance benefits. These benefits are "payable to or for the benefit of an injured person. . . . ." MCL 500.3112. These "benefits are payable as loss accrues" and "within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained." MCL 500.3142(1) and (2). ***Because plaintiff submitted a claim for personal protection insurance benefits*** for the benefit of Smith, the injured person and defendant's insured, ***plaintiff was entitled to payment*** within thirty days of defendant's receipt of reasonable proof of the medical services provided and the cost of such services. Consequently, plaintiff was entitled to attempt enforcement of the penalty interest provision of the no-fault act, MCL 500.3142.
>
> Further, contrary to the trial court's conclusion, ***the fact that plaintiff was not the injured person is not dispositive. MCL 500.3112 specifically contemplates the payment of benefits to someone other than the injured person*** as reflected by its inclusion of the phrase "benefits are payable to or for the benefit of an injured person" and by its discharge of an insurer's liability upon payment made in good faith to a payee "who it believes is entitled to the benefits . . . ." . . . ***Moreover, MCL 500.3142 does not limit the right to seek penalty interest solely to the injured person*** and if the Legislature intended to limit the penalty interest provision, it could have done so. MCL 500.3142(1) could have been written as "personal protection insurance benefits are payable to the injured person as loss accrues." However, the judiciary may not engraft such a limitation under the guise of statutory construction. *See Hagerman v Gencorp Automotive*, 457 Mich. 720; 579 N.W.2d 347 (1998). Therefore, the trial court improperly denied plaintiff the right to attempt enforcement of the penalty interest provision, MCL 500.3142; accordingly, we reverse and

> remand for a determination whether payments for medical services rendered by plaintiff were overdue. [*Id* at 39-40 (emphasis added).]

In concluding that Lakeland Neurocare could enforce the act's attorney fee provision, MCL 500.3148(1), the court again held that a healthcare provider is a *claimant*:

> Next, we consider whether plaintiff was entitled to attempt enforcement of the attorney fee provision of the no-fault act. . . .
>
> Defendant contends that the word "claimant" means that only the injured person may pursue attorney fees. However, undefined words contained in statutes are given meaning as understood in common language, considering the text and subject matter in which they are used. . . . We also may refer to a dictionary for the definition of a word that is not defined in the statute. . . . The word "claimant" is defined as "a person who makes a claim." *Random House Webster's College Dictionary* (1997). The relevant dictionary definitions of the word "claim" include "a demand for something as due; an assertion of a right or an alleged right," and "a request or demand for payment in accordance with an insurance policy. . . ." [*Id* at 40-41.]
>
> [B]ecause plaintiff properly submitted a claim for personal protection insurance benefits for the benefit of defendant's insured, plaintiff was entitled to such payment within the time limits imposed by the no-fault act. Consequently, ***plaintiff was a claimant within the plain meaning of the statute*** and, thus, had the right to attempt recovery of its attorney fees expended in pursuit of recovering overdue benefits. [*Id* at 40-41 (emphasis added and citations omitted.)]

In holding that a healthcare provider can enforce the act's penalty provisions, *Lakeland* necessarily held that a provider has a claim for PIP benefits.[7]

State Farm incorrectly claims that *Lakeland* did not decide whether a healthcare provider has a no-fault claim because State Farm in that case did not dispute Lakeland Neurocare's right to bring a lawsuit. But *Lakeland did* decide that a provider has a claim for no-fault benefits. In holding that Lakeland Neurocare could enforce no-fault penalties, the court

[7] This Court also denied the insurer's application for leave to appeal in *Lakeland*, 467 Mich 909; 655 NW2d 554 (2002).

held that a healthcare provider is a claimant under the no-fault act. This issue was necessary to the court's holding, and the court decided it in favor of healthcare providers. *Lakeland* squarely holds that healthcare providers have a claim for no-fault benefits against no-fault insurers.

Indeed, *Wyoming Chiropractic Health Clinic, PC v Auto Owners Ins Co*, 308 Mich App 389, 397-98; 864 NW2d 598 (2014), rejected State Farm's argument:

> Auto-Owners argues that this Court did not discuss the issue whether a healthcare provider is entitled to sue an insurer for PIP benefits in *Lakeland Neurocare* because the issue was uncontested on appeal. . . . However, this Court's reasoning in *Lakeland Neurocare* applies to a healthcare provider's claim for PIP benefits. This Court reasoned that a healthcare provider is entitled to enforce the penalty provision of the no-fault act because a healthcare provider is entitled to payment of the PIP benefits. Therefore, the fact that a healthcare provider is entitled to payment, as well as the fact that a healthcare provider can sue to enforce the penalty provision of the no-fault act, indicates that ***a healthcare provider may bring a cause of action to recover the PIP benefits under the no-fault act.*** [(Emphasis added.)]

Since *Munson* and *Lakeland*, this Court has acknowledged a healthcare provider's right to bring a claim for no-fault benefits against a no-fault insurer. In *Community Resource Consultants Inc v Progressive Mich Ins Co*, 480 Mich 1097; 745 NW2d 123 (2008), this Court held that a provider could not avoid the one-year-back rule, MCL 500.3145(1), by applying the insurer's later payments to previously denied invoices. In reaching this conclusion, this Court reasoned that the provider should have brought a claim for benefits and no-fault penalties:

> Plaintiff's remedy for defendant's refusal to pay was provided by statute. A payment is overdue "if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained." MCL 500.3142(2). Overdue payments are assessed a penalty of "simple interest at the rate of 12% per annum." *Id.* §3142(3). Plaintiff was required to file an action for the overdue payments within 1 year of when the losses were incurred. *Id.* §3145(1). [*Id* at 1098.]

Recently, in *Wyoming Chiropractic*, *supra*, the Court of Appeals again held that a healthcare provider has a claim against a no-fault insurer for no-fault benefits. The court noted that it had previously "discussed the issue whether a healthcare provider may sue an insurer for PIP benefits under the no-fault act." *Id* at 393. The court's summary of the relevant case law includes the following:

- "In *Munson Med Ctr v Auto Club Ins Ass'n* . . . [t]his Court noted that the plaintiff had a 'right to be paid for the injureds' no-fault medical expenses' under the no-fault statute." *Id*.

- "[I]n *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*, the issue before this Court was whether . . . a healthcare services provider[] was entitled to enforce the penalty interest and attorney fee provisions of the no-fault act against . . . a no-fault insurer. . . . This Court analyzed the plain language of MCL 500.3112 and determined that the plaintiff was entitled to prompt payment because the plaintiff brought a claim for PIP benefits 'for the benefit of' the injured individual when the plaintiff submitted a claim for PIP benefits to the defendant." *Id* at 393-94.

- "[I]n *Univ of Mich Regents v State Farm Mut Ins Co*, one issue that this Court discussed was whether the plaintiffs' claim for medical expenses under the no-fault act was barred by the applicable statute of limitations even though the plaintiffs were a political subdivision of the state of Michigan. . . . The defendant argued that the plaintiffs' claim was subject to the statute of limitations because the plaintiffs' claim derived from the insured individual's claim. This Court disagreed and clarified that, '[a]lthough plaintiffs may have derivative claims, they also have direct claims for personal protection insurance benefits.' This was because the plaintiffs governed a hospital that provided medical care . . . ." *Id* at 394-95 (emphasis added).

After summarizing the case law, the court held that "Wyoming Chiropractic had standing to bring a cause of action against Auto-Owners for PIP benefits under the no-fault act." *Id* at 396.

State Farm criticizes the decisions cited in *Wyoming Chiropractic*.[8] But the *Wyoming Chiropractic* court rejected those same criticisms. *E.g., id* at 394-95 (refuting criticism of *Regents*); *id* at 396-97 (refuting criticism of *Lakeland*). State Farm does not address the court's responses. Nor does State Farm acknowledge that this Court denied leave to appeal in *Wyoming Chiropractic*. 497 Mich 1029; 863 NW2d 54 (2015). *Wyoming Chiropractic* correctly held that healthcare providers have claims for PIP benefits.

Most recently, in *Chiropractor Rehab Grp, PC v State Farm Mut Auto Ins Co*, 313 Mich App 113; 881 NW2d 120 (2015), the Court of Appeals again held that healthcare providers have claims for PIP benefits against no-fault insurers. Tracking *Munson*, *Lakeland*, and the statutory analysis above, the Court of Appeals explained that the no-fault act gives healthcare providers a claim against insurers:

> [A] healthcare provider's ***right to reimbursement*** for medical expenses in a first-party no-fault action is evident in the statutory language of MCL 500.3112, especially when the language is considered in context with MCL 500.3105, 500.3107, and 500.3157. . . . [T]he plain language of the statute reveals a Legislative intent to allow either the injured person or a party that provided benefits to an injured person to recover the payment of benefits from an insurer; the injured person is not the only party who has this right.
>
> ***
>
> [G]iven the text of MCL 500.3112, especially when read in conjunction with MCL 500.3105, 500.3107, MCL 500.3157, and this Court's previous interpretations of the language, we conclude that the statutory scheme of the no-fault act indicates that ***the Legislature intended to confer standing on a healthcare provider to bring a claim against an insurer in order to enforce the provider's right to be reimbursed*** for medical services rendered to an injured party covered under a no-fault policy. [*Id* at 123-24 (emphasis added, and citation omitted).]

[8] This brief addresses State Farm's criticisms of the cited decisions in connection with its discussion of each of those cases. For example, State Farm's criticism of *Lakeland*, *supra* is addressed above.

Contrary to State Farm's assertions, the cases finding that healthcare providers have a claim against no-fault insurers are based on the plain language of the no-fault act.

State Farm cites no case holding that a healthcare provider lacks a claim against a no-fault insurer, and none exists. Instead, State Farm relies on three distinguishable cases. State Farm cites *Belcher v Aetna Casualty & Surety Co*, 409 Mich 231, 243; 293 NW2d 594 (1980), for the proposition that "benefits are made payable only to injured persons or [their] surviving dependent . . . ." But *Belcher* did not address whether a healthcare provider has a claim against a no-fault insurer. Nor did it interpret the phrase "or for the benefit of" in MCL 500.3112. Indeed, *Belcher* did not involve a healthcare provider or allowable expenses.

Rather, the issue in *Belcher* was whether a no-fault insurer owes survivor's loss benefits to the dependent(s) of an uninsured owner (*i.e.*, an owner excluded from coverage by MCL 500.3113(b)). *Id* at 236. No party disputed that the dependents in the consolidated cases were claimants under the act. Thus, *Belcher* is distinguishable. The Court of Appeals has reached this same conclusion. *Wyoming Chiropractic, supra* at 400 ("[T]he issue in *Belcher* was whether survivors of uninsured, deceased individuals could recover survivors' loss benefits. . . . The Michigan Supreme Court did not discuss whether a healthcare provider could recover PIP benefits under the no-fault act . . . .").

State Farm also cites *In re Hales Estate*, 182 Mich App 55, 58; 451 NW2d 867 (1990), for the proposition that "benefits payable under the no-fault act belong to the injured person." But *Hales* also did not address whether a provider has a claim against an insurer.

Rather, the issue in *Hales* was whether the injured person's mother had a right to retain benefits paid by the no-fault insurer that were duplicative of benefits paid by BCBS. In other words, *Hales* was a *probate dispute* between the injured person and his mother. The

probate court held that the injured person had the right to retain the duplicative benefits, and the Court of Appeals affirmed. Accordingly, *Hales* is distinguishable. Again, the Court of Appeals has reached this same conclusion. *Wyoming Chiropractic*, *supra* at 400 ("This case can be distinguished from *Hales* because Wyoming Chiropractic alleges that it was entitled to reimbursement from Auto-Owners for chiropractic services performed . . . while the plaintiff in *Hales* sought to recover duplicate benefits under her son's no-fault policy.").

Finally, State Farm cites *Hatcher v State Farm Mut Auto Ins Co*, 269 Mich App 596, 606; 712 NW2d 744 (2005), for the proposition that "the right to benefits . . . belongs to the injured person." But yet again, *Hatcher* does not address whether a healthcare provider has a claim against a no-fault insurer.

Rather, *Hatcher* involved a minor's claims for no-fault benefits, which were brought through her next friend, the minor's mother. The language that State Farm cites stands for the uncontroversial proposition that, because the mother filed suit as the daughter's next friend, the mother was asserting the daughter's right to benefits.

Importantly, *Hatcher* reached that conclusion in response to *State Farm's argument* that the attendant care claim belonged to the mother, not the injured minor. State Farm made this argument to avoid the tolling effect of MCL 600.5851, which applies to claims brought by minors. *Hatcher*, *supra* at 599-600 ("State Farm contends that the "claimant" in the instant case is Kimberly Hatcher [the mother], not Aris Hatcher [the injured minor] . . . .").

In support of this position, *State Farm argued that MCL 500.3112 expressly grants healthcare providers claims for no-fault benefits*. In its application for leave to appeal, **Exhibit 1**, pp. 6-9, State Farm stated:

> In express terms, §3112 contemplates in most cases one proper person to whom the benefits should be paid. The injured person

> may be that person (as will be the case with work loss or, sometimes, replacement services), but may not necessarily be that person as to payment for medical expenses. ***Indeed, where services have been rendered, the proper payee is the health care provider,*** not the injured person. . . . *See Lakeland Neurocare Centers v State Farm*, 250 Mich App 35, *lv den*, 467 Mich 909 (2002) . . . .
>
> ***
>
> §3112['s] . . . express language contemplates and addresses the possibility of a "person . . . entitled to the benefits" or a "proper person to receive the benefits" other than the injured person. . . . ***Section 3112 expressly recognizes the possibility of an entitlement to benefits in someone other than the injured person.*** [(Bold and italics added; other emphasis removed.)]

Put simply, State Farm argued in *Hatcher* that a claim for no-fault medical expenses belongs to the healthcare provider. State Farm's position in *Hatcher* is the exact opposite of the one that it now advocates to this Court.[9]

Unlike State Farm's flip-flopping, our Court of Appeals has, for decades, consistently and correctly held that a healthcare provider has a claim against a no-fault insurer for PIP benefits. It has addressed and rejected all of State Farm's arguments. Indeed, the Court of Appeals has *never* held that healthcare providers lack a claim for PIP benefits against a no-fault insurer. This Court, likewise, has acknowledged that healthcare providers have a claim for PIP benefits against a no-fault insurer, and it has repeatedly declined to review the Court of Appeals' decisions finding this right. Under the plain language of the no-fault act and decades of case law, healthcare providers have claims for no-fault benefits against no-fault insurers.[10]

---

[9] State Farm even argued that *In re Hales Estate* is "unworthy of precedential effect . . . should not be followed." (Ex. 1, p. 10.)

[10] State Farm also argues that medical providers do not have a claim as third-party beneficiaries of the insurance policy. None of the lower courts in this case addressed this argument, and the record is not sufficient to do so. As State Farm admits, third-party beneficiary status is determined by the language of the contract. (State Farm Br., p. 28.) But here, the State Farm policy is not part of the record. Accordingly, this issue is not ripe for decision.

2. Our courts have correctly held that a healthcare provider has an independent claim when the injured person is eligible for PIP benefits.

Our courts have also correctly held that healthcare providers' claims are both independent and derivative. In the legal context, independent means "[n]ot subject to the control of influence of another." *Black's Law Dictionary* (10th ed). "Derivative" means "[s]omething that has developed from or been produced from something else." *Id.* Accordingly, a provider's claim is derivative of the injured person's eligibility for no-fault benefits—*i.e.*, the injured person has suffered an eligible injury and is not excluded by a permissible coverage exclusion. But otherwise, the provider's claim is independent. Our courts have correctly reached this result.

For example, in *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55; 535 NW2d 529 (1995), the Court of Appeals held that a healthcare provider is the real party in interest to seek benefits for the provider's services. In that case, the provider plaintiffs had treated Auto Club's insureds and billed Auto Club, but Auto Club denied the claims. The providers then sued to recover no-fault benefits for that treatment.

Auto Club argued that the providers were not the real parties in interest because the Michigan Chiropractic Legal Action Committee selected them to bring the lawsuit. The Court of Appeals rejected this argument and held that the providers were the real parties in interest and owned the claims. As the court explained:

> The purpose of the [real party in interest] rule is to protect the defendant by requiring that the claim be prosecuted by the party who by the substantive law in question ***owns the claim*** asserted against the defendant.
>
> ***
>
> [E]ach of the claims asserted by plaintiffs relate to products or services that were provided by them personally to ACIA's insured and for which they billed AICA but were denied payment. . . . ***[T]he asserted claims belong only to plaintiffs***. Therefore, plaintiffs are the real parties in interest.

***

> [T]he rights and legal obligations of which plaintiffs seek a determination in the declaratory judgment portion of this action are rights and obligations arising out of their own personal relationship with AICA. [*Id* at 95-96 (emphasis added and internal citations and quotations omitted).]

Hofmann's reasoning applies to a healthcare provider's claim vis-à-vis an injured person. A provider's claim relates to the provider's treatment and to the insurer's denial of the provider's charges. Because the no-fault act gives the providers the right to charge and requires insurers to pay those charges, the provider's claim relates to its own relationship with the insurer. Accordingly, the provider is the real party in interest to bring its claim.

Importantly, the injured persons' eligibility for benefits was not at issue in *Hofmann*. Rather, Auto Club had denied the providers' claims because Auto Club believed that the treatment fell outside the scope of chiropractic practice, and therefore was not an allowable expense. *Id* at 60. Because the patients' eligibility was not an issue, the providers' claims in *Hofmann* were not derivative. Rather, the providers' claims were independent, and the Court of Appeals correctly found that they were the real parties in interest and owned the claims.

Similarly, *Regents of Univ of Michigan v State Farm Mut Ins Co*, 250 Mich App 719, 733; 650 NW2d 129 (2002), held that a healthcare provider has an independent claim. There, one of the issues was whether MCL 500.3145(1), the no-fault one-year statute of limitations, or MCL 600.5821(4), the limitless statute of limitations for state actions to recover the cost of care and treatment of persons in hospitals, applied to the provider's claim.

State Farm argued that MCL 500.3145(1) applied because the provider's claim derived from the injured person's claim, and the injured person was subject to MCL 500.3145(1). The Court of Appeals rejected this argument. It held that, although the provider's claim was partially derivative, the claim was also direct—*i.e.*, independent:

> Travelers and State Farm also argue that MCL 600.5821(4) does not apply in this case because plaintiffs' claim derives from Estes [the injured person] and Estes is subject to MCL 500.3145. We disagree. ***Although plaintiffs may have derivative claims, they also have direct claims for personal protection insurance benefits***. [*Id* at 733.[11]]

State Farm incorrectly contends that the court made the above statement "in passing." (State Farm Br., p. 22.) But the above statement is a *holding*. It disposed of *State Farm's* argument that MCL 500.3145(1) applied to the provider's claim because that claim was derivative of the injured person's claim. In rejecting this argument, the Court of Appeals correctly recognized that the provider's claim was derivative of the injured person's *eligibility* for no-fault benefits—for example, whether Estes was domiciled with a resident relative was one issue in the case. But the court held that the provider's claim was otherwise independent—for example, for purposes of determining which statute of limitations applied. *Regents* squarely and correctly addresses the scope of a provider's claim for no-fault benefits.

Most recently, in *Chiropractor Rehab Grp*, *supra*, the Court of Appeals again held that a healthcare provider's claim is derivative of the injured person's eligibility for no-fault benefits, but is otherwise independent. After summarizing the relevant case law, including some of the cases on which State Farm relies, the court held that a healthcare provider's claim "is dependent on the insured's eligibility for no-fault benefits." *Id* at 130.

Importantly, the court clarified that its holding does *not* mean that the provider's claim always rises or falls with the injured person's claim. Rather, when the injured person is eligible for no-fault benefits, other defenses specific to the injured person, like the statute of limitations, do not affect the provider's claim. As the court explained:

---

[11] Later in the opinion, the court held that held that plaintiffs were "claimants" under the no-fault act because they "sought recovery of money expended for the medical care of Estes." *Id* at 739. As such, plaintiffs could recover attorney's fees under MCL 500.3148.

> [I]n our view, whether an injured party is eligible for benefits is a different question than whether an injured party may recover benefits when that injured party fails to timely file a cause of action to recover benefits that the injured party is eligible to receive. Were the question before us, we would conclude that an injured party's failure to timely bring suit would not, in and of itself, bar a provider's timely action against the insurer. An injured party may be eligible for benefits under MCL 500.3105(1) even though his or her claim is barred by the one-year statute of limitations under MCL 500.3145(1). ***In such a case, a provider's claim, which is dependent on the injured party's eligibility, would be unaffected.*** [*Id* at 130 n.9 (emphasis added).]

Thus, as with the cases before it, *Chiropractor Rehab Grp* correctly holds that a healthcare provider's claim is derivative of the injured person's eligibility for no-fault benefits, but is otherwise independent.

The cases on which State Farm relies either support this conclusion, or they are inapposite. Both *Bahri v IDS Prop Cas Ins Co*, 308 Mich App 420, 423; 864 NW2d 609 (2014), and *TBCI, PC v State Farm Mut Auto Ins Co*, 289 Mich App 39, 43; 795 NW2d 229 (2010), held that the injured person's fraud barred both the injured person's claim and the provider's claim. An injured person's fraud triggers a coverage exclusion in a typical no-fault policy. That is, fraud affects the injured person's *eligibility* for no-fault benefits. Because the injured persons in *Bahri* and *TBCI* were not eligible for no-fault benefits, neither were the providers.

State Farm also relies on *Moody v Home Owners Ins Co,* 304 Mich App 415; 849 NW2d 31 (2014). But *Moody* addressed the amount in controversy; it did not address whether healthcare providers have independent or derivative claims. *Id* at 419 (noting that the cases "concern[] the jurisdiction of the district court under MCL 600.8301(1) when a plaintiff presents evidence and arguments far in excess of the district court's $25,000 amount-in-controversy jurisdictional limit."); *see also id* at 426 ("The central issue in all three appeals pertains to the application of MCL 600.8301(1) . . . .").

Additionally, *Moody* is not good law. In *Hodge v State Farm Mut Auto Ins Co*, 2016 Mich LEXIS 1094 (June 6, 2016)(MSC No. 149043)(**Exhibit 2**), this Court reversed one of the cases consolidated in *Moody* on the same issue—the amount in controversy.

To the extent that *Moody* remains good law and addresses whether a provider's claim is direct or derivative, it supports Covenant's position. The court explained that the provider's claims were derivative of Moody's *eligibility* for no-fault benefits:

> Specifically, the providers' claims are dependent on establishing Moody's claim that he suffered "accidental bodily injury arising out of the . . . use of a motor vehicle," MCL 500.3105(1), that they provided "reasonably necessary products, services and accommodations for [Moody's] care, recovery, or rehabilitation," MCL 500.3107(1)(a), and that at the time of the accident, Moody was "domiciled in the same household" as his father who was insured by Home Owners, MCL 500.3114(1). The providers' and Moody's claims with respect to the requisites of Home Owners' liability are therefore identical. [*Id* at 440-41]

The procedural posture of *Moody* further supports this conclusion. The providers brought separate lawsuits with separate claims for medical expenses, which were consolidated for trial with Moody's case. This posture and the Court of Appeals' statements are consistent with prior case law and with Covenant's position. A healthcare provider's claim is derivative of the patient's eligibility for no-fault benefits, but it is otherwise independent.

State Farm also cites *Michigan Head & Spine Institute, PC v State Farm Mut Auto Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued January 21, 2016 (Docket No. 324245)("*MHSI*"), and implies a conflict with the Court of Appeals' ruling in this case. But *MHSI* is inapposite. It holds that a jury's finding that "all bills related to the accident have been paid" is res judicata as to a healthcare provider's later suit for its medical bills. *Id* at 2. In other words, the jury found that the patient was not *eligible* for any additional benefits, and that finding barred a healthcare provider's later claim for no-fault benefits.

MHSI does not address the issue presented here: whether an insurer's settlement payment bars a provider's claim when the insurer received notice in writing of the provider's claims before entering into the settlement with the insured. Because this case addresses a different issue, it does not conflict with *MHSI*.

To the extent that *MHSI* applies, it supports Covenant's position that a healthcare provider's claim is derivative of a patient's eligibility for no-fault benefits, but is otherwise independent. As the court explained:

> [W]hile a healthcare provider has ***independent standing*** to bring a lawsuit against a no-fault insurer, the fact remains that there is an interdependence between the claims of a healthcare provider and an injured party, such that a healthcare provider's eligibility to recovery medical expenses is dependent upon the injured party's ***eligibility*** for no-fault benefits . . . . [*Id* at 3 (emphasis added and quotations and citations omitted).][12]

Finally, State Farm relies on *Clark v Progressive Ins Co*, 309 Mich App 387; 872 NW2d 730 (2015). But *Clark* is inapposite. There, the patient entered into an "all claims" settlement with Progressive. When the patient later "discovered" an additional surgery bill that she did not include in the settlement, she unsuccessfully argued to have the settlement set aside. *Clark* stands for the uncontroversial proposition that a *patient's* "all claims" settlement bars the *patient's* later claim for a medical bill.

State Farm claims that the patient sought to set aside the settlement "in support of a subsequent provider lawsuit." (State Farm Br., p. 31.) But nothing in the Court of Appeals' opinion suggests this. No healthcare provider was a party to *Clark*. And *Clark* does not mention, let alone decide, any potential claims by healthcare providers.

Our courts have uniformly held that a healthcare provider's claim is derivative of the injured person's eligibility for no-fault benefits, but it is otherwise independent. And

[12] Additionally, unpublished opinions are not precedentially binding. MCR 7.215(C)(1).

logically, this makes sense. If the injured person did not suffer accidental bodily injury, or if the injury did not arise out of a motor vehicle accident, then the provider's treatment for the injury is not compensable under no-fault. The same holds true if the injured person is ineligible for coverage because of a permissible policy or statutory exclusion, like those in MCL 500.3113. But the healthcare provider's claim is independent in all other respects. The provider may be governed by its own statute of limitations (*Regents* and *Chrio Rehab*, *supra*); the provider has the right to charge a reasonable amount (MCL 500.3157); and the provider must prove that its treatment was reasonably necessary (MCL 500.3107). Under the no-fault act and controlling case law, healthcare providers have independent claims for PIP benefits against a no-fault insurer when the insured is eligible for no-fault benefits.

C. State Farm has waived any argument that providers lack an independent claim for no-fault benefits.

Contrary to its current arguments, State Farm readily admitted to the trial court that healthcare providers have a direct right to reimbursement:

> [W]e don't take exception to the cases that plainly have now said there is a ***direct right of reimbursement*** . . . I do not quarrel with anything [counsel for Covenant] cited in his brief in that regard." [JA 63a.]

In its brief opposing State Farm's motion for summary disposition, Covenant argued that "providers, like Covenant, have an independent right to recover their charges from no-fault insurers, like Defendant." (JA 37a.) In support of this argument, Covenant cited MCL 500.3112, *Lakeland*, and *Regents*, among other authorities. By admitting that providers have a direct right of reimbursement and not contesting "anything [counsel for Covenant] cited in his brief in that regard," State Farm has admitted that providers (a) have claims against no-fault insurers and (b) that those claims are direct (*i.e.*, independent). As such, State Farm has waived

the arguments it now makes to this Court. *See Walters v Nadell*, 481 Mich 377, 387; 751 NW2d 431 (2008) (failure to dispute an issue below waives it on appeal).

II. REGARDLESS OF WHETHER ITS CLAIM IS INDEPENDENT OR DERIVATIVE, A HEALTHCARE PROVIDER IS "SOME OTHER PERSON" UNDER MCL 500.3112.

The second sentence of MCL 500.3112 states: "Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of ***some other person***." (Emphasis added.) Whether its claim is independent or derivative, a healthcare provider is "some other person."

The word "some" means "being an undetermined or unspecified one." *Random House Webster's College Dictionary* (2005). The word "other" means "different from the one mentioned." *Id.* And "person," "includes . . . [a] corporation[] and any other legal entity." MCL 500.114. Accordingly, the phrase "some other person" includes an undetermined or unspecified legal entity different from the "person who [the insurer] believes is entitled to the benefits."

When an insurer makes a settlement payment to the injured person, the phrase "some other person" includes a healthcare provider. In that context, the insurer believes that the injured person is entitled to the benefits. A healthcare provider is an undetermined or unspecified legal entity different from the injured person. Indeed, "injured person" and "person" have separate statutory definitions. MCL 500.3109(2); MCL 500.3114. As such, the healthcare provider is "some other person" within the meaning of the second sentence of MCL 500.3112.

This conclusion holds true regardless of whether the provider's claim is independent, derivative, or both. To the extent that a healthcare provider's claim is independent, it is the claim of some other person because it is not influenced or controlled by the person to whom the no-fault insurer pays benefits.

To the extent that a provider's claim is derivative of the injured person's claim, it is also the claim of some other person. "Derivative" means "[s]omething that has developed from or been produced by something else." *Black's Law Dictionary* (10th ed). Thus, a derivative claim is something other than the underlying claim; it is a claim that has developed from or been produced by the underlying claim. Said differently, a derivative claim is based on the underlying claim, but it is something additional to or different from the underlying claim. As such, a provider's claim is "the claim of some other person," even if it is derivative.

The plain language of MCL 500.3112 supports this conclusion. The second sentence of the statute does not distinguish between "independent" and "derivative" claims. Rather, it refers to "the claim of some other person." As explained above, a claim is a "demand as a right or as due," and healthcare providers have a right to be paid by the no-fault insurer. Accordingly, regardless of whether the provider's claim is independent or derivative, it is the "claim" of "some other person" within the meaning of MCL 500.3112.

Case law further supports this conclusion. To the extent that a healthcare provider's claim is derivative, it is analogous to a spouse's derivative claim for loss of consortium, as State Farm admits. (State Farm Br., p. 32.) As this Court has held, a loss of consortium claim is "an *independent cause of action*." *Wesche v Mecosta Co Rd Comm'n*, 480 Mich 75, 85; 746 NW2d 847 (2008)(emphasis added). This is because "[a]lthough a loss-of-consortium claim is derivative of the underlying bodily injury, it is nonetheless regarded as *a separate cause of action* and not merely an item of damages." *Id* (emphasis added); *Hannay v DOT*, 497 Mich 45, 74; 860 NW2d 67 (2014). As such, a derivative claim is the claim of "some other person," because it is a separate claim based on the underlying injury.

This reasoning applies to a provider's claim for no-fault benefits. Like a claim for loss of consortium, a claim for no-fault benefits is based on the underlying bodily injury. *See* MCL 500.3105 ("an insurer is liable to pay benefits for accidental bodily injury . . ."); MCL 500.3111 (referring to "the person whose injury is the basis of the claim); MCL 500.3148(2) (referring to "the injury on which the claim is based."); *Belcher*, *supra* at 242.[13] Accordingly, to the extent that a provider's claim is derivative of the underlying injury, it is nonetheless an independent cause of action. As such, the provider's claim is the claim of some other person.

The fact that an injured spouse cannot release the other spouse's claim for loss of consortium further shows that a derivative claim is the claim of "some other person." In *Oldani v Lieberman*, 144 Mich App 642; 375 NW2d 778 (1985), the wife suffered the underlying injury. While litigating her claims, she filed for divorce. Although the husband had filed his own lawsuit, he tried to intervene in the wife's lawsuit to assert a loss of consortium claim. The trial court denied his motion, so he continued to pursue his own lawsuit. The wife later settled her lawsuit. The trial court in the husband's lawsuit held that the settlement barred the husband's derivative loss of consortium claim. *Id* at 644-646.

The Court of Appeals reversed. It held that the wife's settlement did not bar the husband's loss of consortium claim:

> Harry Oldani [] had a viable loss of consortium claim arising out of his wife's damage claim . . . . Harry's claim was derivative of Judith's claim, i.e., if Judith's claim had been litigated on the merits and she had lost, Harry would have had no claim. . . .
>
> Under these circumstances, where Harry was kept out of Judith's suit through no fault of his own, Judith's settlement with defendants did not operate to release Harry's claims against

[13] "The threshold question to be resolved where a person makes a claim for no-fault benefits is whether the injury upon which the claim is based is the type of injury which the act is designed to compensate. Focus must be placed upon the injury. The nature of the injury and the circumstances under which it was suffered dictate whether no-fault insurance may operate as a source of recovery for losses flowing from the injury." *Id.*

> defendants. ***Judith did not have authority to settle and release Harry's claim.*** Therefore, the trial court erred in granting accelerated judgment in favor of defendants and against Harry's loss of consortium claim. Accordingly, we reverse and remand this case to the trial court for trial of Harry's loss of consortium claim. [*Id* at 650 (emphasis added).]

Oldani's reasoning applies to a healthcare provider's no-fault claim. Like the husband, the provider has a viable claim for no-fault benefits based on the injured person's eligibility for benefits. And just as the wife could not settle the husband's claim after he asserted it, the patient cannot settle the healthcare provider's claim after the provider asserts it. This is particularly true where, as here, the provider is unaware of the patient's lawsuit and is excluded from the settlement discussion. The second sentence of MCL 500.3112 codifies this principle by providing that the insurer's payment does not discharge the noticed claim of "some other person," like a healthcare provider. Accordingly, a healthcare provider is "some other person" under MCL 500.3112, regardless of whether the provider's claim is independent or derivative.

State Farm incorrectly argues that "the claim of some other person" means claims by dependents for survivor's loss benefits. (State Farm Br., p. 40.) But this argument contravenes the language of the statute. The second sentence of MCL 500.3112 refers to "[p]ayment by an insurer in good faith of personal protection insurance benefits, to or for the benefits of a person who it believes is entitled to the benefits . . . ." The Legislature's use of the broad terms "personal protection insurance benefits" and "the benefits" demonstrates that this sentence applies to more than just survivor's loss benefits. *See* MCL 500.3107 (identifying the items for which PIP benefits are payable). If the Legislature had intended the narrow application urged by State Farm, the Legislature would have referred to "personal protection insurance benefits . . . payable for a survivor's loss" or "benefits payable for a survivor's loss," as it did in MCL 500.3108. State Farm reads into MCL 500.3112 words that are not there. The words that

the Legislature actually used show that a healthcare provider's claim, whether independent or derivative, is the claim of some other person.

III. MCL 500.3112 ALLOWS, BUT DOES NOT REQUIRE, A HEARING. BUT ABSENT A HEARING, AN INSURER'S SETTLEMENT WITH THE INJURED PERSON DOES NOT DISCHARGE ITS LIABILITY FOR A HEALTHCARE PROVIDER'S NOTICED CLAIM.

A. The plain language of MCL 500.3112 supports this conclusion and the Court of Appeals' holding.

To determine the extent to which a hearing is required under MCL 500.3112, the statute must be considered as a whole. *See Krohn*, *supra* 183. MCL 500.3112 states:

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
>
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
>
> (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

As discussed above, the first sentence describes a no-fault insurer's two independent payment obligations.

The second sentence addresses the effect of an insurer's payment to a person who it believes is entitled to the benefits (like the injured person). As the Court of Appeals correctly

recognized, the plain language of this sentence contemplates two situations. The first situation occurs when the insurer does not have notice in writing of the claim of some other person when the insurer makes a good faith payment. This first situation does not trigger the "unless" clause, so the payment discharges the other person's claim. The second situation occurs when the insurer receives notice in writing of the claim of some other person *before* the insurer makes a good faith payment. This second situation *does* trigger the "unless" clause, so the insurer's payment does *not* discharge the other person's claim. (COA Opinion, JA 81a-82a.)

In this case, State Farm admittedly had notice in writing of Covenant's claim months *before* State Farm settled with Mr. Stockford. Accordingly, this case triggers the "unless" clause of MCL 500.3112, and "State Farm's payment to Stockford did not discharge its liability to [Covenant]." (COA Opinion, JA 82a.)[14]

The third through fifth sentences of MCL 500.3112 describe the insurer's options "[i]f there is doubt about the proper person to receive the benefits." The word "doubt" commonly means "to be uncertain about." *Random House Webster's College Dictionary* (2005). Uncertainty about the proper person to receive the benefits arises, for example, when an insurer receives notice in writing of the claim of some other person before it makes a good faith payment of PIP benefits to a person it believes is entitled to the benefits.

In that circumstance, the third through fifth sentences give the insurer two options to protect itself from the effect of the second sentence's "unless" clause. Under the fifth sentence, the insurer may, without a court order, pay certain PIP benefits to the dependents and

[14] State Farm argues that the Court of Appeals incorrectly found that "notice in writing" means that Covenant's bills and medical records were sent to State Farm. (State Farm Br., p. 34-35 n.15.) But the Court of Appeals did not address what constitutes "notice in writing." Rather, State Farm *admitted* that it had received notice in writing of Covenant's claim before it settled with Mr. Stockford. (MSD Hearing Transcript, JA 65a, p. 7:14-15.) Additionally, the settlement specifically mentions Covenant's claim, which demonstrates that State Farm had notice of Covenant's claim before entering into the payment and release. (JA 19a.) The Court of Appeals implicitly held that State Farm had notice in writing of Covenant's claims because State Farm admitted that it did.

surviving spouse of the injured person. But if the noticed claim is from "some other person" besides the dependents or spouse—like a healthcare provider—then the third sentence allows the insurer to seek an "appropriate order" from the circuit court. The fourth sentence allows the court to "designate the payees and make an equitable apportionment." The insurer can then pay no-fault benefits pursuant to that order and avoid the "unless" clause of the second sentence.

Because the third sentence uses the word "may," the insurer is not required to apply for an appropriate order. But per the fifth sentence, without such an order, the insurer may pay only certain PIP benefits to dependents and the surviving spouse. A payment to any other claimant—including the injured person—does not avoid the second sentence's "unless" clause. Put simply, an insurer is not required to apply to the circuit court for an appropriate order before it pays no-fault benefits to an injured person, even when the insurer has received prior notice in writing of a healthcare provider's claim. But if the insurer chooses not to do so, then it remains liable for the healthcare provider's noticed claims, per MCL 500.3112's "unless" clause.

This is precisely the Court of Appeals' holding in this case. Contrary to State Farm's argument, the Court of Appeals did not hold that an insurer must always seek a hearing before paying benefits. (State Farm Br., p. 41.) Rather, the Court of Appeals actually said:

> [T]he plain text of the statute provides that if the insurer has notice in writing of a third party's claim, then the insurer cannot discharge its liability to the third party simply by settling with its insured. Such a payment is not in good faith because the insurer is aware of a third party's right and seeks to extinguish it without providing notice of the affected third part. Instead, the statute requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated. That was not done in this case. Accordingly, pursuant to the plain language of the statute, because State Farm had notice in writing of Covenant Medical's claim, State Farm's payment to Stockford did not discharge its liability to Covenant Medical. [(COA Opinion, JA 81a-82a.)]

Read as a whole, the Court of Appeals' opinion holds that, because State Farm admittedly had notice in writing of Covenant's claim before it paid Mr. Stockford, MCL 500.3112's "unless" clause was triggered. State Farm could have applied to the circuit court for an appropriate order, but did not do so. As a result, State Farm's payment to Mr. Stockford does not discharge its liability to Covenant. Accordingly, the Court of Appeals correctly held that, absent a hearing, an insurer's settlement with the injured person does not discharge its liability for a healthcare provider's noticed claim.

B. An insurer cannot circumvent MCL 500.3112 with a release.

State Farm argues that an insurer can discharge its liability for the noticed claim of some other person if the injured party executes a settlement agreement that releases the other person's claim. (State Farm's Br., p. 35.) But an insurer cannot circumvent MCL 500.3112's "unless" clause by contract. Allowing an insurer to do so would render that clause nugatory. That is, the statute's "unless" clause would be meaningless if an insurer could discharge its liability for a healthcare provider's noticed claim by settling with only the injured party *without regard to when the insurer received notice in writing of the provider's claim*.

If MCL 500.3112 meant as State Farm claims, then the settlement alone would govern the effect of an insurer's payment—as if MCL 500.3112 did not exist. State Farm admitted to this in its application. (State Farm's App., p. 17)("[T]he second sentence of Section 3112 is irrelevant when a release is involved.") This result violates the rule of statutory construction that "a court should presume that every word has some meaning and should avoid any construction that would render any part of a statute surplusage or nugatory." *City of Royal Oak v Se Oakland Cnty Res Recovery Auth*, 257 Mich App 639, 642; 669 NW2d 322 (2003).

The example on page 35 of State Farm's brief demonstrates how State Farm's position attempts to circumvent MCL 500.3112. In that example, State Farm admits that an

insurer's liability to Dependent Y is not discharged by paying no-fault benefits to Dependent X after the insurer has received notice in writing of Dependent Y's claim to those same benefits. But under State Farm's position, the insurer could discharge its liability to *Dependent Y* merely by having *Dependent X* release Dependent Y's claims in exchange for the insurer's payment.

In other words, State Farm wants to accomplish by contract exactly what MCL 500.3112 prohibits. State Farm wants to discharge the noticed claim of some other person by paying only the injured person and without giving the other person notice. As the Court of Appeals correctly recognized, the statute's plain language prohibits this. (COA Opinion, JA 81a.)

Additionally, State Farm's position contravenes case law. As explained above, the injured person cannot release the provider's separate, noticed claim. *See Oldani*, *supra*. In this regard, a release is like the statute of limitations—a patient-specific defense that does not affect the healthcare provider's claim. *See Chiropractor Rehab Grp*, *supra*.[15]

In support of its position, State Farm cites *Miller v State Farm Mut Auto Ins Co*, 410 Mich 538, 568; 302 NW2d 537 (1981). But the portion of that case on which State Farm relies addressed whether "the calculation of survivors' loss benefits under § 3108 include consideration of a 'personal consumption factor' relating to purely personal expenses of the

---

[15] Even if State Farm were correct that it could circumvent MCL 500.3112 by contract, the release in this case does not do so. On the contrary, the release contemplates that medical providers—including Covenant—*could bring no-fault claims against State Farm* and that Mr. Stockford would indemnify State Farm for those claims:

> [T]he undersigned agrees to indemnify, defend and hold harmless State Farm Mutual Automobile Insurance Company from any liens or demands made by any provider . . . including . . . Saginaw Covenant Medical Center . . . for payment made or services rendered to Jack H. Stockford in connection with any injuries resulting from the above described accident. [(JA 19a, p. 3.)]

This language shows that State Farm and Mr. Stockford contemplated that medical providers, including Covenant, could bring claims for no-fault benefits against State Farm. Accordingly, even if State Farm could circumvent MCL 500.3112 by contract, the release here does not do so.

deceased that are avoided by reason of his death." *Id* at 565. It does not address whether an insurer can circumvent MCL 500.3112's "unless" clause through a release.

State Farm also cites *Michigan Head & Spine Institute, P.C. v State Farm Mut Auto Ins Co*, 299 Mich App 442; 830 NW2d 781 (2013). But that case, too, is inapposite. The issue there was "whether an insured's release bars a healthcare provider's claim for payment for medical services rendered to the insured *after* the release was executed." *Id* at 448 (emphasis added). Because the services were rendered after the settlement, the insurer did not have notice in writing of the provider's claim before the settlement. Thus, the Court of Appeals correctly distinguished *Michigan Head & Spine* because that case did not address the issue here: whether an insurer's settlement bars a provider's claim when the treatment was rendered, and the insurer received notice in writing of the provider's claim, *before* the settlement. (COA Opinion, JA 82a.) The "unless" clause of MCL 500.3112 controls this issue, but not the issue presented in *Michigan Head & Spine*. *See Chiropractors Rehab*, *supra* at 129 n. 7 (noting that this issue "raises particular issues under the text of MCL 500.3112.").

State Farm also relies on *Moody*, *supra*. But *Hodge*, *supra*, overruled *Moody*, and *Moody* does not address settlement. Rather, the issue was the amount in controversy. *Id* at 419, 426. On this issue, the court held that "consolidation for trial resulted in merging the claims [Moody's claims and the provider's claims] for purpose of determining the amount in controversy under MCL 600.8301(1)." *Id* at 443. Any comments regarding the effect of a patient's release are dicta. Moreover, those comments rely solely on *Michigan Head & Spine*, *supra*, and they do not consider the timing of the release and payment, as required by MCL 500.3112. *Moody* is inapposite.

Finally, State Farm's reliance on *Miller v Citizens Ins Co*, 490 Mich 904; 804 NW2d 740 (2011), is also misplaced. As State Farm admits, the issue there was whether a patient's attorney could take a fee from the amount recovered for a healthcare provider's bill when the provider did not bring its own lawsuit or intervene in the patient's lawsuit. (State Farm's Br., p 38.) This Court stated that MCL 500.3112 does not apply to that issue because the statute "does not encompass an award of attorney fees to an insured's counsel." *Id* at 741. *Miller* does not address, under MCL 500.3112, the impact of a settlement on a provider's noticed claim for no-fault benefits.

To the extent that *Miller* applies, it supports the Court of Appeals' holding. This Court held that the settlement between the patient and the insurer only settled claims between the insurer, the patient, and her attorney—not the healthcare provider:

> No-fault benefits are "payable to or for the benefit of an injured person . . . ." MCL 500.3112. In this case, through settlement, the benefits were paid to plaintiff, and her attorney asserted an attorney's charging lien over the settlement proceeds. ***Thus, the effect of this [settlement] was only to settle claims as between the insurer, plaintiff, and her attorney.*** The circuit court's order of dismissal pursuant to the settlement agreement did not have the effect of extinguishing the DMC's right to collect the remainder of its bill from plaintiff. Such a result could not have been achieved without an explicit waiver, or at least unequivocal acquiescence, by the DMC, which was not obtained. [*Id* at 741 (Emphasis added.)[16]]

MCL 500.3112 plainly states that a settlement payment to the injured person does not discharge an insurer's liability for a healthcare provider's noticed claim. The statute allows an insurer to avoid that impact by seeking an appropriate order from the circuit court. But if the

[16] That this Court only mentioned the DMC's right to collect the remainder of its bill from the patient does not change this conclusion, as State Farm claims. (State Farm Br., p. 38 n. 17.) The DMC had not asserted a claim against the insurer, so there was no reason for this Court to address that issue.

insurer chooses not to do so, then the insurer is bound by the statute's "unless" clause. The insurer cannot circumvent the plain language of MCL 500.3112 by contract.

IV. HEALTHCARE PROVIDERS' CLAIMS AND THE COURT OF APPEALS' RULING FURTHER THE PURPOSE OF THE NO-FAULT ACT.

The act is designed "to provide victims of motor vehicle accidents with assured, adequate, and prompt reparation for certain economic losses." *Cruz v State Farm Mut Auto Ins Co*, 466 Mich 588, 595; 648 NW2d 591 (2002) (citation omitted). The act remedies "long delays, inequitable payment structure, and high legal costs" in the tort system. *Id.*

Allowing healthcare providers to bring claims expedites payment to the healthcare provider, particularly when the insurer disputes the claim. This meets the goal of prompt reparation. *Wyoming Chiro*, *supra* at 401. Provider claims also give the provider a remedy against the insurer (the proper payer) when the insurer wrongfully denies a claim. *Id.* This furthers the goal of prompt reparation and also avoids inequitable payment structures. *Id.* Without claims for no-fault benefits against the insurer, healthcare providers would have to sue the injured person whenever the insurer wrongfully refused to pay. This would subject the injured person to unnecessary legal costs, multiply lawsuits, and further delay benefits.

The Court of Appeals' ruling in this case also furthers the goal of prompt payment and avoids inequitable payment structures. By holding that an insurer cannot discharge a provider's noticed claim by settling with only the injured person, the court's ruling requires an insurer to deal directly with the provider, which expedites payment to the healthcare provider. It also prevents the insurer from foisting upon the injured person the burden of negotiating settlements with both the insurer and the healthcare providers(s), which avoids inequitable payment structures. Indeed, if the burden of resolving healthcare providers' claims is a great as

State Farm and the amici assert, then as between sophisticated national insurance companies and injured persons, the burden of those negotiations should fall on the well-heeled insurers.

State Farm's sole policy argument against provider claims and the Court of Appeals' ruling is State Farm's allegation of increased litigation. (State Farm Br., p. 42.) But any increased litigation is because insurers, like State Farm, wrongfully deny claims. If no-fault insurers properly paid claims, there would be little to no litigation. Moreover, if State Farm's reading of the no-fault act were correct, litigation will not decrease. Rather, the burden of bringing suit will simply shift to patients, which ill-serves the purpose of the act.

Conclusion

The no-fault act may not be used by an insurer "as a weapon against rightful payees to a payee's unjustified economic detriment." *Lakeland*, *supra* at 43. But that is exactly what State Farm and other no-fault insurers are attempting to do. State Farm attempts to use the no-fault act as a weapon to bar healthcare providers, who are rightful payees under the act, from challenging its wrongful denials, instead forcing injured persons to bear the burden and expense of doing so. The no-fault act does not allow this, and neither should this Court. Accordingly, Covenant requests that this Court affirm the Court of Appeals in all respects.

MILLER JOHNSON
Attorneys for Plaintiff-Appellee

Dated: September 15, 2016

By /s/ Christopher J. Schneider
Richard E. Hillary, II (P56092)
Christopher J. Schneider (P74457)
Business Address:
45 Ottawa Avenue, S.W., Suite 1100
P.O. Box 306
Grand Rapids, Michigan 49501-0306
Telephone: (616) 831-1700